Arizona Medical Board

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DRAFT MINUTES FOR REGULAR SESSION MEETING
Held on June 4, 2008 and June 5, 2008
9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members

William R. Martin III, M.D., Chair
Douglas D. Lee, M.D., Vice Chair
Dona Pardo, Ph.D., R.N., Secretary
Robert P. Goldfarb, M.D., F.A.C.S.
Patricia R. J. Griffen
Andrea E. Ibáñez
Ram R. Krishna, M.D.
Todd A. Lefkowitz, M.D.
Lorraine L. Mackstaller, M.D.
Paul M. Petelin Sr., M.D.
Germaine Proulx
Amy J. Schneider, M.D., F.A.C.O.G.

EXECUTIVE DIRECTOR'S REPORT

Lisa Wynn, Executive Director, informed the Board that pending the approval from the Arizona Department of Administration and the Governor's Office, the Chief Medical Consultant position had been offered to William Wolf, M.D. Dr. Wolf has been on staff as a part-time medical consultant since February 2005. Ms. Wynn reported that the Agency has completed the conversion to a new database. She stated the conversion was successful and complimented staff on their efforts.

REVIEW AND APPROVAL OF SUBSTANTIVE POLICY STATEMENT REGARDING DUTIES OF HOSPITALS AND PHYSICIANS TO REPORT PEER REVIEW INFORMATION

Karen Owens, on behalf of Arizona Hospital and Healthcare Association (AzHHA) was present and spoke during the call to public. She stated that hospitals and medical staff leaders were requesting the Board's guidance with regard to mandated reporting. Ms. Owens stated that she looks forward to continued communication with the Board and its staff.

Dr. Goldfarb presented the Substantive Policy Statement (SPS) to the Board and thanked the stakeholders who provided input. Dr. Goldfarb stated that he recalled cases that came before the Board in the past regarding the hospital's medical director for failing to report to the Board. He said in two cases, either the hospital's attorney advised that the action was not reportable, or the peer review committee did not know who was required to report. Dr. Goldfarb stated that the Board recognizes the importance of peer review in healthcare institutions and that premature reporting to the Board may have an unintended affect on the peer review process.

Dr. Goldfarb clarified that the peer review committee does not need to complete the peer review process prior to reporting and that not all peer review committee members need to report; however, the medical director is responsible for ensuring a report has been made. Dr. Petelin complimented Dr. Goldfarb and Board staff for their work on the SPS and questioned how it would be disseminated. Ms. Wynn stated that the Agency will possibly work with AzHHA to distribute the document to the audience most affected by it. Ms. Wynn also stated that the SPS will be available on the Board's web site and in its newsletter, Primum.

MOTION: Dr. Goldfarb moved to approve the Substantive Policy Statement regarding duties of hospitals and physicians to report peer review information.
SECONDED: Ms. Griffen
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

REVIEW AND CONSIDERATION OR REQUEST FOR CLARIFICATION REGARDING OFFICE BASED SURGERY RULES

Included in the Board's Office Based Surgery Rules (Rules) was a restriction prohibiting physicians from performing office based surgery on patients requiring admission to the hospital following the procedure. Physicians have raised concerns that healthy patients admitted for overnight stay in recovery care centers for wound care would fall into this restriction. Board members

discussed making a clarification to that section to state that recovery care centers are not hospitals and physicians may admit patients to them for overnight monitoring if there are no underlying health issues involved in the patient's admission.

MOTION: Dr. Krishna moved to clarify that recovery care centers are not hospitals, as referred to in R4-16-703, and that patients can be admitted overnight to recovery care centers for wound care. He further moved to place this clarification under the Frequently Asked Questions on the Board's website.
SECONDED: Ms. Griffen
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

REVIEW AND APPROVAL OF PROPOSED RULEMAKING: R4-16-205, FEE RULES
Ms. Wynn informed the Board that the Board voted to increase its fees in September 2006 and Staff has complied with that decision. Staff has worked with the Agency's contracted Rule writer to revise the Fee Rules to conform with Agency practice. Ms. Wynn requested the Board to approve opening a rule package with regard to a fee increase pertaining to R3-16-205.

MOTION: Dr. Krishna moved to approve the opening of a rule package to increase fees.
SECONDED: Ms. Griffen
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

BOARD OFFSITE MEETING AGENDA
Dr. Martin asked if there were any items that Board members would like to discuss at the Board's offsite meeting scheduled for September of 2008. Dr. Martin stated that he would like to hold an After Action Review with Board members as he believes the meetings are valuable and will benefit the Board in the future. He also stated that he would like to discuss how to better manage the Call to Public and plan the Board's next holiday party. Board members also asked to add topics such as a hospital's duty to report malpractice actions taken against physicians and proxy signatures.

CHAIR'S REPORT
Board members said their goodbyes to Kelly Sems, M.D., Chief Medical Consultant. Dr. Sems has submitted her resignation and stated that she has accepted a position as the Medical Director of an insurance company that will require less commute time. Dr. Martin presented Dr. Sems with a plaque in recognition and appreciation of her service. Dr. Sems first served as an Internal Medical Consultant for the Board and currently serves as the Chief Medical Consultant. Board members expressed their appreciation to Dr. Sems and stated that she has been an incredible asset to the Agency.

LEGAL ADVISOR'S REPORT
Anne Froedge, Assistant Attorney General, reported to the Board that the Legal Advisor position is still open. Monty Lee, Licensing Enforcement Section Chief of the Attorney General Office, informed the Board that the position has been re-advertised and there are two potential candidates. Mr. Lee stated that one candidate is from the US Attorney's Office and the other had previously worked at the Attorney General's Office. Board members expressed their appreciation to the Attorney General's Office for their hard work.

APPROVAL OF MINUTES
MOTION: Dr. Krishna moved to approve the April 1, 2008 Emergency Teleconference Meeting Minutes, Including Executive Session; April 2-3, 2008 regular Session Meeting Minutes, Including Executive Session; April 2, 2008 Continuance Summary Action Meeting Minutes, Including Executive Session; and the April 3, 2008 Regular Session Meeting Minutes, Including Executive Session.
SECONDED: Ms. Griffen
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

ADVISORY LETTERS
MOTION: Dr. Krishna moved to issue an Advisory Letter for item numbers 1, 2, 3, 5, 6, 8, 9, 10, 12, 13, 14, 17, 18, 19, 21, 22, 25, 27, 28, and 29.
SECONDED: Dr. Goldfarb
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-07-0435A	AMB	WAYNE E. CHIAVACCI, M.D.	26813	Issue an Advisory Letter for failing to follow up on lab tests and evaluate a patient with known congenital heart disease, pneumonia, and anemia for possible endocarditis. This was a one time occurrence that does not rise to the level of discipline.
2.	MD-07-0435B	AMB	JOSEPH CERJAN, M.D.	22609	Issue an Advisory Letter for failing to obtain blood and urine cultures in a 14 month-old child with fever and a history of congenital heart disease. This matter does not rise to the level of discipline.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-07-0435C	AMB	DAVID R. MAKI, M.D.	19493	Issue an Advisory Letter for failing to fully investigate a possible endocarditis diagnosis in a patient with a congenital heart defect, abnormal labs, and pneumonia. This was a one time occurrence that does not rise to the level of discipline.
4.	MD-07-0858A	L.L.	ERIC S. HAZELRIGG, M.D.	20772	Issue an Advisory Letter for inadequate medical records. This was a one time occurrence that does not rise to the level of discipline.

Dr. Hazelrigg addressed the Board during the call to public. He stated that after a two week trial, the jury came to the conclusion that he met the standard of care in this case. Dr. Hazelrigg admitted that he failed to completely document a complete breast exam of the patient, but that he completed the record two weeks later when he saw her in follow-up. He stated his medical records were not inadequate and requested the case be dismissed.

Ingrid Haas, M.D., Medical Consultant, summarized the case for the Board. She informed the Board that Dr. Hazelrigg did not amend the medical record until eighteen months later, according to the medical records Dr. Hazelrigg submitted to the Board. Dr. Haas referred Board members to the medical record included with Dr. Hazelrigg's response and confirmed that the date of his amendment was eighteen months after the exam was conducted and after the patient had been diagnosed with breast cancer. Dr. Haas opined that Dr. Hazelrigg met the standard of care in this case, but his medical records were inadequate.

MOTION: Dr. Krishna moved to issue an Advisory Letter for inadequate medical records. This was a one time occurrence that does not rise to the level of discipline.
SECONDED: Ms. Proulx
VOTE: 10-yay, 1-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-07-0574A	AMB	MALCOLM K. MILLER, M.D.	21278	Issue an Advisory Letter for failure to identify fractures on x-ray. This was a one time occurrence that does not rise to the level of discipline.
6.	MD-07-0594A	AMB	MICHAEL J. JOHNSON, M.D.	31247	Issue an Advisory Letter for failing to communicate significant findings directly to a referring physician regarding an abnormal x-ray report. This was a one time occurrence that does not rise to the level of discipline.
7.	MD-07-0656A	M.L.	PETER Y. LEE, M.D.	28340	Issue an Advisory Letter for failing to conduct further workup on a symptomatic patient with significant cardiac past medical history. This was a one time occurrence that does not rise to the level of discipline.

Dr. Lee addressed the Board during the call to public. The patient's family alleged that Dr. Lee deviated from the standard of care by not ordering an echocardiogram. He requested the Board dismiss this case stating that an Advisory Letter was unwarranted. Bhupendra Bhatheja, M.D., Medical Consultant, summarized the case for the Board. Board staff found that Dr. Lee failed to conduct further work up on a symptomatic patient with significant cardiac history and recommended an Advisory Letter.

MOTION: Dr. Mackstaller moved to issue an Advisory Letter for failing to conduct further workup on a symptomatic patient with significant cardiac past medical history. This was a one time occurrence that does not rise to the level of discipline.
SECONDED: Dr. Petelin
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-07-1001A	D.D.	ALI M. MOSHARRAFA, M.D.	24276	Issue an Advisory Letter for inadequate medical records. This was a minor or technical error that does not rise to the level of discipline.

Dr. Petelin was recused from this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-07-0896A	K.P.	THOMAS W. MOFFO, M.D.	17768	Issue an Advisory Letter for inadequate medical records. This was a minor or technical error that does not rise to the level of discipline.
10.	MD-07-0790A	AMB	HETALKUMAR C. SHAH, M.D.	25006	Issue an Advisory Letter for inadequate medical record documentation. 10 hours non-disciplinary CME in medical recordkeeping. This matter does not rise to the level of discipline.
11.	MD-07-0704A	J.M.	KATHRYN M. LANDHERR, M.D.	29888	Issue an Advisory Letter for inadequate medical record documentation. This was a one time occurrence that does not rise to the level of discipline.

Dr. Schneider was recused from this case. Dr. Landherr summarized the case to the Board during call to public. JM alleged that Dr. Landherr failed to perform an adequate hysterectomy. Dr. Landherr noted that there was concern with her failure to document a discussion with JM regarding biopsy results and treatment options.

MOTION: Dr. Martin moved to accept the Motion for Good Cause.
SECONDED: Dr. Krishna
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.

MOTION PASSED.

Ingrid Haas, M.D., Medical Consultant, presented this case to the Board. She stated that it is not the standard of care to discuss the surgery at the time of the surgical preoperative admission. Dr. Haas found it inadequate that Dr. Landherr relied on the patient's history and physical exam for her dictation, as this did not provide the patient with the risks and benefits of the procedure. Dr. Petelin noted that Dr. Landherr had removed only one of the patient's ovaries when the plan was to remove both. Dr. Haas noted that Dr. Landherr did not initially communicate this to the patient. The Board concluded that this matter does not rise to the level of discipline.

MOTION: Dr. Petelin moved to issue an Advisory Letter for inadequate medical record documentation. This was a one time occurrence that does not rise to the level of discipline.
SECONDED: Dr. Krishna
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
12.	MD-07-1007A	S.C.	MICHAEL Y. SULEIMAN, M.D.	26524	Issue an Advisory Letter for failing to obtain proper lab and examination prior to treating with testosterone and for failing to discuss the risks and benefits of testosterone therapy with the patient. This was a one time occurrence that does not rise to the level of discipline.
13.	MD-07-1118A	AMB	EDWARD C. JUAREZ, M.D.	17307	Issue an Advisory Letter for action taken by another state. This was a one time occurrence that does not rise to the level of discipline.
14.	MD-08-0083A	AMB	ABEDON A. SAIZ, M.D.	24387	Issue an Advisory Letter for failure to perform a visual inspection of the colon at the time of surgical resection. This was a technical error that does not rise to the level of discipline.
15.	MD-07-0611A	L.C.	NALINI S. BHALLA, M.D.	30546	Issue an Advisory Letter for failing to adequately communicate her transfer of practice to a patient and covering colleagues, for failing to completely fill out the assisted living facility form with medication dosages prior to admittance, and for failing to provide current contact information with the Board.

Kathleen Coffer, M.D., Medical Consultant, summarized the case for the Board. Board staff found that Dr. Bhalla failed to adequately communicate her transfer of practice to a patient and covering colleagues, failed to completely fill out the assisted living facility form with medication dosages prior to admittance, and failed to provide current address information with the Board. Board staff recommended the Board issue Dr. Bhalla an Advisory Letter.

MOTION: Dr. Goldfarb moved to issue an Advisory Letter for failing to adequately communicate her transfer of practice to a patient and covering colleagues, for failing to completely fill out the assisted living facility form with medication dosages prior to admittance, and for failing to provide current contact information with the Board.
SECONDED: Dr. Mackstaller
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
16.	MD-07-0631A	J.L.	ALTON V. HALLUM, M.D.	21585	Return for further investigation.

Dr. Schneider was recused from this case. Dr. Mackstaller stated that she knew Dr. Hallum, but it would not affect her ability to adjudicate the case. Dr. Hallum addressed the Board during call to public. He stated that JL alleged that he performed a procedure that was out of his scope of practice. Dr. Hallum reported that there were no complications immediately following surgery. JL did not follow up with Dr. Hallum once complications were noted and was treated by another provider in a different community. Dr. Hallum requested the Board dismiss this case as he has instituted changes in his practice that addressed the concerns.

Dr. Petelin pulled this case for discussion and questioned if the procedure performed was appropriate for JL. JL's right ovary was removed when the plan was to remove her left ovary. The Board noted that Dr. Hallum received consent for that procedure. According to Dr. Hallum, JL requested a tummy-tuck; however, this was not documented in her medical record. Board members noted that gynecological oncologists are not trained to perform abdominoplasties.

MOTION: Dr. Krishna moved to invite Dr. Hallum for a Formal Interview.
SECONDED: Dr. Petelin
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Martin moved to reopen this case.
SECONDED: Dr. Goldfarb
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

Board members clarified that the case will return for further investigation prior to the Formal Interview.

AMENDED MOTION: Dr. Lee moved to return this case for further investigation.
SECONDED: Ms. Proulx
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
17.	MD-07-0754A	S.C.	PATRICE HOUSTON, M.D.	32080	Issue an Advisory Letter for inadequate medical records. This matter does not rise to the level of discipline.
18.	MD-07-0770A	W.C.	ANTHONY K. HEDLEY, M.D.	13693	Issue an Advisory Letter for inadequate medical records. This was a one time occurrence that does not rise to the level of discipline.

Dr. Krishna stated he knew Dr. Hedley, but it would not affect his ability to adjudicate the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
19.	MD-07-0823A	AMB	SEAN O. CASEY, M.D.	30325	Issue an Advisory Letter for failing to identify portal venous gas and findings consistent with mesenteric ischemia on an abdominal CT scan. This was a one time occurrence that does not rise to the level of discipline.
20.	MD-07-0891A	A.G.	RONALD J. CASTRO, M.D.	12701	Dismiss.

Dr. Castro was required to maintain AG's medical record until November 2008, six years after the last date of treatment. Dr. Castro stated that the record may have been lost in storage. Dr. Mackstaller noted that Dr. Castro attempted to find the record and she recommended this case be dismissed.

MOTION: Dr. Mackstaller moved for dismissal.
SECONDED: Dr. Krishna
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
21.	MD-07-0954A	AMB	JOSEPH M. SCOGGIN, M.D.	30290	Issue an Advisory Letter for inappropriately performing a hip arthroplasty resulting in a sustained permanent nerve injury. This was a minor technical error that does not rise to the level of discipline.
22.	MD-07-0801A	R.A.	JULIE A. HEATHCOTT, M.D.	29469	Issue an Advisory Letter for failing to obtain RA's blood type and Rh factor prior to the admission of Rhogam. This was a one time occurrence that does not rise to the level of discipline.

RA addressed the Board during the call to public. She stated she had a miscarriage because her progesterone was never tested and Dr. Heathcott was unaware that she was Rh(-). RA had another miscarriage three months later.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
23.	MD-07-0879A	AMB	MANUEL DE JESUS CHEE, M.D.	11024	Return for further investigation, re-notice the physician, and then invite him in for a Formal Interview.

Dr. Petelin pulled this case for discussion noting similar cases before the Board in the past. He stated that a physician has to have a higher index of suspicion that something is wrong when there is unexplained pain resulting from a hernia repair.

MOTION: Dr. Goldfarb moved to invite Dr. Chee for a Formal Interview.
SECONDED: Dr. Schneider

The Board was concerned with Dr. Chee's failure to recognize and/or identify a postoperative complication, resulting in actual harm. Staff informed the Board that this case would need to return for further investigation to re-notice the physician with A.R.S. §32-1401 (27)(ll). Drs. Goldfarb and Schneider withdrew their motion.

MOTION: Dr. Petelin moved to return this case for further investigation, re-notice the physician, and then invite him in for a Formal Interview.
SECONDED: Dr. Goldfarb
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
24.	MD-07-1002A	R.B.	MAKONNEN G. HABTEMARIAM, M.D.	21618	Dismiss.

Dr. Habtemariam addressed the Board during the call to public. He summarized the case and stated that he met the standard of care. His attorney, Gordon Lewis also addressed the Board during the call to public and stated that an Advisory Letter was unwarranted and requested dismissal. Dr. Goldfarb pulled this case for discussion. Dr. Habtemariam ordered scheduled dosing of Librium for alcohol withdrawal without first informing the patient and/or her husband. Dr. Mackstaller commented that in her experience, alcohol withdrawal is done prior to any discussions with the patient or family. Board members noted that Dr. Habtemariam did not place the patient on a formal protocol as he only ordered the Librium.

MOTION: Dr. Goldfarb moved for dismissal.

SECONDED: Dr. Mackstaller
VOTE: 7-yay, 3-nay, 1-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
25.	MD-07-0918A	AMB	NICHOLAS J. ROSATI, M.D.	16871	Issue an Advisory Letter for failing to identify a second nodule on x-ray. This was a one time occurrence that does not rise to the level of discipline.
26.	MD-07-0712A	D.T.	SONITA K. SINGH, M.D.	31940	Issue an Advisory Letter for failing to completely assess a patient with severe aches, vomiting, low blood pressure, and rapid pulse; for making a diagnosis of bronchitis that was not consistent with presenting complaints and findings; and for failing to adequately supervise office staff. This was a one time occurrence that does not rise to the level of discipline.

Dr. Bhatheja summarized the case for the Board. Board staff found that the wrong diagnosis was made and the wrong medical advice was provided to the patient. Board staff recommended the Board issue Dr. Singh an Advisory Letter as this was a one time occurrence. Dr. Goldfarb was concerned that Dr. Singh was not supervising his staff who provided medical advice to patients.

MOTION: Dr. Goldfarb moved to issue an Advisory Letter for failing to completely assess a patient with severe aches, vomiting, low blood pressure, and rapid pulse; for making a diagnosis of bronchitis that was not consistent with presenting complaints and findings; and for failing to adequately supervise office staff. This was a one time occurrence that does not rise to the level of discipline.
SECONDED: Dr. Krishna
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
27.	MD-07-0887A	AMB	KHALED M. SALEH, M.D.	29262	Issue an Advisory Letter for failing to communicate the urgent need for a consultation directly to the surgeon. This was a one time occurrence that does not rise to the level of discipline.
28.	MD-07-1022A	G.S.	KIANOUSH KIAN, M.D.	22618	Issue an Advisory Letter for failing to promptly refer a patient to a retinal specialist following complicated cataract surgery where nuclear material was retained in the eye. This matter does not rise to the level of discipline.

Dr. Kian addressed the Board during the call to public. He requested that the Board allow a retinal specialist to review his case prior to taking final action. He stated that surgical intervention would not have been necessary until medical treatment failed. He stated that his referral had nothing to do with the final outcome in this case and requested the Board either allow the review by the specialist or dismiss the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
29.	MD-07-0701A	H.S.	ROSEMARY V. WILSON, M.D.	22119	Issue an Advisory Letter for failing to maintain adequate medical records on a patient. This was a one time (one patient) occurrence that does not rise to the level of discipline.

REVIEW OF EXECUTIVE DIRECTOR (ED) DISMISSALS
MOTION: Dr. Martin moved to uphold the ED dismissal in item numbers 1, 2, 5, 6, 7, 8, 9, 10, 12, 13, 15, 16, 19, 20, 21, 22, 23, 25, 28, 29, and 30.
SECONDED: Dr. Lee
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-07-0579A	J.M.	MARVIN J. SLEPIAN, M.D.	20296	Uphold ED dismissal.
2.	MD-07-0538A	P.E.	DENNIS L. ARMSTRONG, M.D.	9947	Uphold ED dismissal.

PE was present and spoke during the call to public. PE stated she had a right hip replacement in May 2006. She stated that she reported pain to Dr. Armstrong and that something was wrong, but he ignored her. PE stated that her right hip is now nineteen to twenty inches too long and asked that the Board hold Dr. Armstrong accountable for his mistake.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-06-0839A	AMB	ALAN C. SCHWARTZ, M.D.	9416	Uphold ED dismissal.

Dr. Goldfarb pulled this case for discussion. Board staff reported to the Board that Dr. Schwartz has withdrawn all Notice of Supervision forms that he had on file with the Board. He is no longer supervising physician assistants and is no longer interested in practicing clinical medicine. However, Board staff discovered that Dr. Schwartz treated and admitted approximately 247 patients to the hospital during the time he alleged he was not practicing.

MOTION: Dr. Goldfarb moved to uphold the ED dismissal.
SECONDED: Dr. Krishna
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-07-0478A	A.K.	SUNDARARAJAN JAYACHANDRAN, M.D.	14860	Uphold ED dismissal.

Dr. Petelin pulled this case for discussion, noting that the Board's outside medical consultant does not currently practice in Arizona. Board staff informed the Board that a medical consultant must hold an active Arizona license to review cases for the Board but that they are not required to practice in the State.

MOTION: Dr. Petelin moved to uphold the ED dismissal.
SECONDED: Dr. Krishna
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-07-0481A	D.D.	ALI M. MOSHARRAFA, M.D.	24276	Uphold ED dismissal.
6.	MD-07-0629A	E.B.	CARRIE J. BURNS, M.D.	29671	Uphold ED dismissal.

EB was present and spoke during the call to public. He stated that he went to the emergency room for suicide prevention, but was not treated as a suicidal patient. He said that Dr. Burns treated him not as a patient, but as an enemy of Dr. Burns' friend and coworker.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-07-0834A	M.D.	DAMASO S. BUENO JR., M.D.	28044	Uphold ED dismissal.
8.	MD-07-0795A	J.L.	JOHN B. CARSON, M.D.	15263	Uphold ED dismissal.

Dr. Krishna stated he knew Dr. Carson, but it would not affect his ability to adjudicate this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-07-0760A	P.J.	EDWARD J. BERGHAUSEN JR., M.D.	30321	Uphold ED dismissal.
10.	MD-07-0771A	A.O.	MOHAMMED T. ALHAMMOURI, M.D.	35178	Uphold ED dismissal.
11.	MD-07-0903A	T.M.	FRANCIS K. TINDALL, M.D.	14589	Uphold ED dismissal.

TM was present and spoke during the call to public. TM expressed her concern with Dr. Tindall's negligence in removing a cyst from her hand and felt Dr. Tindall was impaired at the time of her surgery. TM developed a staph infection two days post surgery. She said Dr. Tindall should be held accountable and asked that the Board reopen her case. Dr. Goldfarb pulled this case for discussion.

Gerald Moczynski, M.D., Medical Consultant, summarized the case for the Board. Once TM developed the infection, she contacted the nurse who then referred her to a hospital where Dr. Tindall was not employed. Dr. Moczynski stated that TM received excellent care from the subsequent physician and that there was no evidence of impairment. Therefore, staff recommended the Board uphold the ED's dismissal.

MOTION: Dr. Goldfarb moved to uphold the ED dismissal.
SECONDED: Dr. Krishna
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
12.	MD-07-0901A	E.B.	KRISTINE A. ROMINE, M.D.	31198	Uphold ED dismissal.
13.	MD-07-0650A	R.K.	KURT E. HEILAND, M.D.	24997	Uphold ED dismissal.
14.	MD-07-0757A	M.D.	PATTI A. FLINT, M.D.	23855	Return for further investigation to conduct a chart review of patients who have undergone facial reconstructive surgery and breast reconstructive surgery.

Paul Giancola addressed the Board on behalf of Dr. Flint. Dr. Martin stated he knew Mr. Giancola, but it would not affect his ability to adjudicate this case. Mr. Giancola requested that the Board uphold the ED dismissal. MD also addressed the Board during the call to public. She claimed that Dr. Flint had placed false entries into her medical record. MD stated that Dr. Flint had entered into her preoperative note that MD had previous scarring, but MD stated that she did not have any scarring until after the procedure was performed by Dr. Flint. MD further stated that her face has been disfigured.

Dr. Petelin pulled this case for discussion noting that Dr. Flint has had several cases before the Board. The medical consultant who reviewed this case found that Dr. Flint used a substandard surgical technique, but opined that she met the standard of care because the postoperative complications were handled. Board members expressed their concern regarding the number of complaints against Dr. Flint that have recently come before the Board. . The Board recommended returning this case for further investigation to conduct a chart review of patients who have undergone facial reconstructive surgery and breast reconstructive surgery.

MOTION: Dr. Petelin moved to return this case for further investigation to conduct a chart review of patients who have undergone facial reconstructive surgery and breast reconstructive surgery.
SECONDED: Ms. Proulx
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.

MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
15.	MD-07-0906A	R.D.	ROBERT W. SNYDER, M.D.	17708	Uphold ED dismissal.

Mike Ryan addressed the Board during the call to public. Mr. Ryan stated that he and Dr. Snyder requested the Board uphold the ED dismissal.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
16.	MD-08-0024A	M.R.	JOEL R. GOODE, M.D.	28515	Uphold ED dismissal.
17.	MD-07-0943A	V.C.	MARIA THERESA A. REYES, M.D.	26134	Uphold ED dismissal.

Dr. Petelin pulled this case for discussion. Board staff found that Dr. Reyes met the standard of care in this case and recommended the Board uphold the dismissal.

MOTION: Dr. Petelin moved to uphold the ED dismissal.
SECONDED: Dr. Schneider
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
18.	MD-08-0015C	A.A.	KENNETH B. GOSSLER, M.D.	23966	Uphold ED dismissal.

AA was present and spoke during the call to public. He stated that his case was not fully investigated and requested the case be re-opened. Dr. Goldfarb pulled this case for discussion. Kelly Sems, M.D., Chief Medical Consultant, presented the case to the Board. AA received epidural injections for back pain and when the steroids were not helping, he was referred to an orthopedist. The orthopedist found that the issue was with AA's hip, not his back.

MOTION: Dr. Krishna moved to uphold the ED dismissal.
SECONDED: Dr. Lee
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
19.	MD-07-0991A	C.H.	LANE R. BIGLER, M.D.	23211	Uphold ED dismissal.

CH was present and spoke during the call to public. CH stated Dr. Bigler treated his squamous cell carcinoma twice by spraying it with nitrogen. CH claimed that Dr. Bigler had informed him that it was not cancerous and CH sought care with another provider who immediately diagnosed the squamous cell and recommended biopsy.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
20.	MD-07-0867A	M.F.	SHARAM DANESH, M.D.	32803	Uphold ED dismissal.

MF was present and spoke during the call to public. She stated that she underwent a procedure and was left with pressure in her eye. She stated her optic nerve has been permanently damaged due to the prolonged pressure that Dr. Danesh left in her eye.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
21.	MD-07-0895A	K.W.	SEAN T. LILLE, M.D.	27453	Uphold ED dismissal.

KW was present and spoke during the call to public along with AC. KW asked that the Board reopen her case to investigate Dr. Lille's failure to diagnose and for patient abandonment. AC also requested that the Board further investigate so that what happed to her does not happen to anyone else.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
22.	MD-07-0824A	W.S.	CAMILLA A. MICAN, M.D.	14099	Uphold ED dismissal.
23.	MD-07-0803A	M.A.	ERIKA DRIVER-DUNCKLEY, M.D.	32461	Uphold ED dismissal.
24.	MD-08-0141A	AMB	FRANCISCO J. HERNANDEZ, M.D.	20754	Uphold ED dismissal.

RU was present and spoke during the call to public. She requested that the Board uphold the ED's dismissal. She stated that the complainant had been a source of great anguish and concern to Dr. Hernandez's practice. Elle Steger, Case Manager presented this case to the Board. The complainant had alleged that Dr. Hernandez was lending his name to the illegal practice of medicine in his clinic. Ms. Steger stated that the complainant did not provide any patient information and Board staff's inspection of his office did not sustain any violations.

MOTION: Dr. Krishna moved to uphold the ED dismissal.
SECONDED: Dr. Petelin
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
25.	MD-07-0781A	Y.J.	HEIDI P. COX, M.D.	35468	Rescind the dismissal and return this case for further investigation to determine whether the patient and family were properly informed of the experience level of the surgeon.

MOTION: Dr. Petelin moved to reopen this case.
SECONDED: Ms. Proulx
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.

MOTION PASSED.

MOTION: Dr. Petelin moved to rescind the dismissal and return this case for further investigation to determine whether the patient and family were properly informed of the experience level of the surgeon.
SECONDED: Ms. Proulx
VOTE: 8-yay, 1-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
26.	MD-07-0781B	Y.J.	PATRICK V. BAILEY, M.D.	35652	Return for further investigation to determine whether the patient and family were properly informed of the experience level of the surgeon.

Renee Coury was present and spoke on behalf of Drs. Cox and Bailey. She requested that the Board uphold the ED's dismissal in both cases. Dr. Petelin pulled this case for discussion. He stated he was concerned that there was no documentation that the physicians ever informed the family of their skill level for the procedure performed.

MOTION: Dr. Petelin moved to return this case for further investigation to determine whether the patient and family were properly informed of the experience level of the surgeon.

Dr. Haas informed the Board that both physicians were included in the patient's signed consent form in the medical record.

SECONDED: Ms. Proulx
VOTE: 8-yay, 1-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
27.	MD-08-0001A	S.B.	STEPHEN S. BROCKWAY, M.D.	17759	Return for further investigation.

DF was present and spoke during the call to public on behalf of her brother, the patient. She stated her family lost her brother in November 2004 to inpatient suicide while he was under the care of Dr. Brockway, his primary provider at The Meadows. She stated that Dr. Brockway failed to follow The Meadows policy, leading to her brother's tragic and preventable suicide. SS was also present and spoke during the call to public. SS stated that Dr. Brockway reduced the patient's monitoring to four hours and placed him in a unit where the staff was not aware of the patient's suicidal ideation. The patient committed suicide four days after presenting to The Meadows.

Bhupendra Bhatheja, M.D., Medical Consultant, presented this case to the Board. The medical consultant who reviewed this case did not find any deviation from the standard of care. Dr. Bhatheja stated that the medical consultant found that Dr. Brockway was the consulting physician in this case, not the patient's primary care provider. Dr. Krishna opined that Dr. Brockway's evaluation and recommendations were thorough; however, he was concerned that Dr. Brockway did not obtain the patient's past medical history prior to his assessment. Dr. Krishna questioned whether the medical consultant had access to the supplemental material provided to the Board that indicated Dr. Brockway was the patient's primary provider. Dr. Krishna requested this case return for further investigation to allow the medical consultant the opportunity to review the supplemental material.

MOTION: Dr. Krishna moved to return this case for further investigation.
SECONDED: Dr. Lee
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
28.	MD-07-1032A	M.C.	THEODORE L. RUDBERG, M.D.	11018	Uphold ED dismissal.

MC was present and spoke during the call to public. She stated that she had power of attorney for her mother, the patient. However, she stated that Dr. Rudberg stopped her mother's insulin without first consulting her. MC also stated that there was nothing in her mother's medical record to support Dr. Rudberg stating that her prognosis was not good.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
29.	MD-08-0004A	J.G.	VERNON R. SCOTT, M.D.	23397	Uphold ED dismissal.
30.	MD-08-0012A	T.L.	ROBERT L. MAHANTI, M.D.	20847	Uphold ED dismissal.

Dr. Lefkowitz was recused from this case. Paul Giancola spoke during the call to public. He gave a brief summary of the case stating that TL was an outside Board medical consultant for a case involving Dr. Mahanti. Mr. Giancola stated that he received TL's review and provided it to four physicians with the same specialty for an external review. He stated that the external reviewers were informed that the Board's materials were confidential and were asked to maintain that confidentiality. Mr. Giancola further stated that obtaining external reviews is very important to the Board's process and requested that the Board uphold the ED dismissal.

Dr. Mahanti addressed the Board during the call to public and stated that TL was biased and provided no outside evidence supporting his standard of care when acting as an OMC. He did not address the academy preferred practice patterns which did not support his standard of care, and ignored exculpatory data in the chart. In addition, Dr. Mahanti stated that TL was not truthful to the Board when he had stated that he never met him. Dr. Mahanti stated that TL had filed a complaint against his attorney to

the Arizona State Bar Association complaining of his representation and reportedly supplied the Bar with materials that Dr. Mahanti had submitted to the Board in his defense. Dr. Mahanti questioned whether the material was privileged information.

Dr. Lefkowitz also addressed the Board during the call to public. Dr. Lefkowitz stated that he was addressing the Board as a former Outside Medical Consultant to the Board in Ophthalmology and not as Board member. He stated that during call to the public, Dr. Mahanti used this platform to defame him and in addition his colleagues on the Board and that Dr. Mahanti's comments concerned Dr. Lefkowitz's role as a consultant and not a Board member. He stated that when asked to review Dr. Mahanti's case in December 2006, he informed Board staff that there would be no conflict as he had not met Dr. Mahanti. He stated that he reviewed the case and found problems with Dr. Mahanti's management and recordkeeping and included those criticisms in his report and that Dr. Mahanti filed a supplementary response. Dr. Lefkowitz received a CD from Board staff that included a letter from Dr. Mahanti's attorney, Paul Giancola, in which there were letters from four Arizona ophthalmologists, supporting Dr. Mahanti's views. He stated the cover letter from the Board to Dr. Mahanti specifically warned him that the Board materials were confidential and must not be shared with anyone other than his attorney and obviously Dr. Mahanti and Mr. Giancola felt they were not answerable to the Arizona Revised Statutes. He further stated that he reported this incident to the Board's former legal counsel, but that no legal opinion was provided. During the August 2007 Board Meeting, Dr. Lefkowitz recused himself from the interview of Dr. Mahanti and the Board voted to issue Dr. Mahanti an advisory letter with CME. He stated that Dr. Mahanti has been bitter and has spoken at several calls to the public; taking issue with the fairness of the Board's opinion. Dr. Lefkowitz stated that he filed a complaint with the Board in January 2008, not as a Board member, but as a private citizen and previous OMC, charging that Dr. Mahanti flagrantly ignored the Board's prohibition against disseminating confidential Board documents. At the same time, he reported that he filed a complaint with the State Bar of Arizona against Mr. Giancola for the same reasons. In sending documents to the Bar, he covered over patient information with a black marker to avoid HIPAA violations, contrary to what Dr. Mahanti had alledged. Dr. Lefkowitz reported that the Board and Bar found no violations and that he has appealed both decisions, as the confidentiality of Board consultants must be protected.

Dr. Lefkowitz stated that he has not experienced any problems adjudicating cases where licensees are represented by Mr. Giancola and that he has often voted in favor of his clients. Additionally, he stated that he is not biased against Dr. Mahanti, as he had not met him or dealt with him in any professional situation.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
31.	MD-08-0040A	R.M.	TODD A. LEFKOWITZ, M.D.	13944	Uphold ED dismissal.

Dr. Lefkowitz was recused from this case and left the room during the Board's deliberations. Dr. Mahanti addressed the Board during the call to public. He stated that at a previous Board meeting, he watched as the Board reprimanded a physician for failing to remove sponges in the abdomen, for failure to treat a postoperative complication, and for failing to review postoperative x-rays that ultimately resulted in additional surgery. Dr. Mahanti stated that this case was an ophthalmology equivalent to that case. Dr. Mahanti alleged that Dr. Lefkowitz failed to address and treat postoperative complications regarding a properly positioned flap to a non-English speaking patient. Dr. Mahanti stated that it was not clear from the medical record if Dr. Lefkowitz was aware of the complication, but if he was, he failed to act upon it. Dr. Mahanti repaired the cornea several months later with the vision decreased, a scarred and partially melting flap, and upset patient. According to Dr. Mahanti, it appeared that Dr. Lefkowitz denied accepting that there was a complication and offered the patient no help. Dr. Mahanti questioned whether the Board could investigate potential incompetence of one of its own members.

Dr. Lefkowitz also addressed the Board during the call to public. He stated that Dr. Mahanti did see a patient that Dr. Lefkowitz had performed LASIX on in March 2005; the patient was noted to have a flap complication which Dr. Lefkowitz had diagnosed on the first post-op day and presented to the senior surgeon. Dr. Mahanti presented this surgeon as a reknowned refractive surgeon, but didn't mention that the surgeon had been disciplined many times by the Board. Dr. Lefkowitz followed the advice of the surgeon and took the patient back to the operating room to explore for an infolded flap but was unable to dissect one and concluded that the falp must have been amputated by the microkeratome during the surgery and noted the senior surgeon did not disagree. Dr. Lefkowitz followed the patient closely until he left the practice in late May 2005. The patient seemed to be doing well and was then seen on a routine basis by Dr. Mahanti who claimed there was a vision problem and that Dr. Lefkowitz had failed to diagnose a flap folding and that he had dissected the folded flap. Dr. Lefkowitz stated the technician who worked with Dr. Mahanti informed him that was not so and there was epithelial ingrowth, but no flap melting as Dr. Mahanti had stated. Dr. Lefkowitz stated that when he filed his complaint against Dr. Mahanti in January 2008, that Dr. Mahanti responded in less than a week by filing his complaint regarding the LASIX patient. He added that there should be no doublt that this was done in retribution for his role as the OMC and to embarrass the Board. He stated that the patient did not come to the Board because she didn't speak English and this was a total fabrication as her English was excellent. Dr. Lefkowitz questioned why Dr. Mahanti went back three years into archives to find a case in which to embarrass him, since he was no longer involved in the active care of this patient. Additionally, he questioned whether this constitutes a HIPAA violation. He requested that the Board uphold the Executive Director's dismissal of this case and hoped that they would discipline Dr. Mahanti for his violation of the Statututes concerning dissemination of Board materials.

Gerald Moczynski, M.D., Medical Consultant, summarized the case for the Board. Dr. Lefkowitz performed Lasik eye surgery on the patient and the patient returned the following day complaining of feeling a foreign body in the eye. Dr. Lefkowitz treated the patient and then documented in follow up that the eye had healed. The outside medical consultant who reviewed this case found no deviations from the standard of care. The reviewer opined that the complication was a technical surgical complication. Dr. Moczynski stated that when Dr. Lefkowitz left the practice, he could no longer care for the patient.

MOTION: Dr. Petelin moved to uphold the ED dismissal.
SECONDED: Ms. Proulx

Dr. Krishna spoke in favor of the motion, noting that the complication was appropriately treated and recognized on postoperative day one. He stated that in review of the medical record, there was no evidence of negligence or abandonment.

VOTE: 8-yay, 0-nay, 0-abstain, 1-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
32.	MD-07-1099A	R.D.	LORRAINE L. MACKSTALLER, M.D.	27143	Uphold ED dismissal.

Dr. Mackstaller was not present for the Board's discussions or deliberations of this case. Board members discussed how they would adjudicate a case regarding a fellow Board member. Dr. Lee commented that there have been situations where a Board member may have had obvious conflicts of interest, but they were able to make an unbiased decision. Dr. Martin stated that Board members should not be treated any differently than other physicians who come before the Board.

MOTION: Dr. Petelin moved to go into executive session.
SECONDED: Ms. Proulx
Vote: 9-yay, 0-nay, 0-abstain, 0-recused, 3-absent.
MOTION PASSED.

The Board went into Executive Session for legal advice at 4:44 p.m.
The Board returned to Open Session at 4:48 p.m.
No deliberations or discussions were made during Executive Session.

The Board initiated this case after receiving a complaint alleging patient abandonment. The outside medical consultant who reviewed the case found that Dr. Mackstaller addressed RD's concerns and ordered the appropriate tests. RD subsequently terminated care with Dr. Mackstaller and established care with another provider. Therefore, the outside medical consultant did not sustain a violation of patient abandonment.

MOTION: Dr. Lee moved to uphold the ED dismissal.
SECONDED: Dr. Petelin
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

OTHER BUSINESS
MOTION: Dr. Lee moved to accept the proposed consent agreement in item numbers 1-7, 9, and 13.
SECONDED: Ms. Proulx
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Martin, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board members were absent: Ms. Ibáñez, Dr. Mackstaller, and Dr. Pardo.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-07-0441A	AMB	HOLLIS E. SHAW, M.D.	15515	Accept proposed consent agreement for a Letter of Reprimand for failure to fully evaluate a patient's anemia, for failure to include ineffective erythropoiesis as part of the differential diagnosis for macrocytic anemia that required a bone marrow aspiration and for failure to consider ecthyma gangrenosum as a possible diagnosis of skin lesions.
2.	MD-07-0848A	AMB	STEPHEN D. GLACY, M.D.	17082	Accept proposed consent agreement for Surrender of an active license.
3.	MD-07-0448A	AMB	GUSTAVE A. MATSON, M.D.	15992	Accept proposed consent agreement for a Decree of Censure for prescribing without performing examinations on four female patients, for failure to coordinate care and communicate with another treating physician of one patient, for failure to consider the possibility that the chronic Fioricet he prescribed to a patient may have been causing analgesic rebound headache and for failure to maintain adequate medical records. Five Years Probation to include quarterly chart reviews and/or pharmacy surveys.
4.	MD-07-0827A	AMB	LYNN M. KEATING, M.D.	19688	Accept proposed consent agreement for a Letter of Reprimand for failure to perform an adequate neurologic examination and for administrating an abdominal computed tomography scan with contrast to a patient with a known allergy to contrast dye. Practice

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
					Restriction for Ten years in that physician shall not practice clinical medicine involving patient care, and is prohibited from prescribing any form of treatment. After two years, Respondent may apply to the Board to request practice restriction to be lifted by demonstrating that she is able to safely practice medicine. The Board may require any combination of physical examinations, psychiatric and/or psychological to determine if respondent is able to safely engage in the practice of clinical medicine.
5.	MD-07-0839A	AMB	DAMON C. DAVIS, M.D.	27240	Accept proposed consent agreement for a Letter of Reprimand for failure to personally evaluate a patient despite being notified twice by nursing staff that the patient was not doing well and for failure to follow up on abnormal computed tomography scan results that he ordered.
6.	MD-07-0844A	AMB	MARIA CECLIA D. DIMAANO, M.D.	13509	Accept proposed consent agreement for a Letter of Reprimand for failure to be readily available and respond to hospital staff in a timely manner and for failure to maintain adequate records.
7.	MD-07-0518A	L.Y.	RAUL M. WEBSTER, M.D.	32815	Accept proposed consent agreement for a Letter of Reprimand for failure to perform a post operative vaginal examination on a patient with continued symptoms and complaints of pain and for failure to maintain adequate records.
8.	MD-07-0374A	AMB	ALEXANDER VILLARES, M.D.	32704	Accept proposed consent agreement for a Letter of Reprimand for failure to timely see two patients with small bowel obstructions and for documenting a physical examination that he did not perform. Within one year obtain 20 hours CME in ethics. The CME shall be in addition to the hours required for the biennial renewal of medical license. Probation to include random chart reviews and shall terminate upon completion of the CME.

Cal Raup was present and spoke during the call to public. He stated that Dr. Villares signed the proposed consent agreement prior to retaining legal counsel. Dr. Villares attempted to withdraw his acceptance of the consent agreement, but Board staff denied his request. Mr. Raup stated that Dr. Villares is not attempting to avoid the discipline, which they agree is appropriate, but did not understand the legal consequences when he signed it. Mr. Raup requested that the Board reject the proposed consent agreement and invite Dr. Villares in for a Formal Interview.

Kelly Sems, M.D., Chief Medical Consultant, summarized the case for the Board. This case was on the Board's prior meeting agenda as a proposed consent agreement. The Board rejected the consent agreement, modified it to include Five Years Probation and CME, and then re-offered it to Dr. Villares. Dr. Sems reported to the Board that Dr. Villares was informed of the fact that he may obtain legal counsel at any time during the course of the investigation. Board members noted that the language included in the consent agreement specifically states that once it is signed, it cannot be withdrawn.

MOTION: Dr. Lee moved to go into executive session.
SECONDED: Dr. Goldfarb
Vote: 9-yay, 0-nay, 0-abstain, 3-recuse.
MOTION PASSED.

The Board went into Executive Session for legal advice at 5:08 p.m.
The Board returned to Open Session at 5:10 p.m.
No deliberations or discussions were made during Executive Session.

MOTION: Dr. Krishna moved to accept the proposed consent agreement for a Letter of Reprimand for failure to timely see two patients with small bowel obstructions and for documenting a physical examination that he did not perform. Within one year obtain 20 hours CME in ethics. The CME shall be in addition to the hours required for the biennial renewal of medical license. Probation to include random chart reviews and shall terminate upon completion of the CME.
SECONDED: Dr. Lee
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Martin, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board members were absent: Ms. Ibáñez, Dr. Mackstaller, and Dr. Pardo.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-07-0562A	M.J.	THOMAS A. VETTO, M.D.	15826	Accept proposed consent agreement for a Decree of Censure for failure to obtain an arterial blood gas to assess respiratory status and to determine whether the patient is retaining carbon dioxide, for repeated failure to take appropriate steps to monitor and recognize an adverse patient response to medications, for continuing to inappropriately administer medications after the

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
					patient's adverse response occurred, for failure to provide continual care of patient while the patient is still in the emergency department, but technically admitted to the hospital and for failure to maintain adequate medical records.
10.	MD-04-0480A	AMB	SIMON OLSTEIN, M.D.	8589	Termination of MAP Probation.

Drs. Martin and Petelin stated that they knew Dr. Olstein, but it would not affect their ability to adjudicate the case. Dr. Olstein was present and spoke during the call to public. He stated that he has been in full compliance with the Board's Monitored Aftercare Program (MAP) for almost three years. He stated that his participation in MAP should be terminated as it has been well established that he was not drug or alcohol dependent He also stated that it has been firmly established that he does not represent a threat or danger to the public.

Kathleen Muller, Physician Health Program, summarized the case for the Board. She stated that the Board initiated this case after receiving notification from the Phoenix Police Department that Dr. Olstein had been arrested at Phoenix Sky Harbor Airport after marijuana and heroin were found in his luggage. Dr. Olstein completed treatment and in June 2005 he entered into a consent agreement for Letter of Reprimand and Probation to participate in MAP. Dr. Olstein requested termination of his MAP Probation, modification to his agreement omitting the details of his criminal arrest and to reflect the dismissed charges. Dr. Olstein further requested that the Board remove the June 2005 agreement from its web site.

In Dr. Olstein's request, it states that since Dr. Olstein was diagnosed with abuse and not dependence, he was a candidate for termination, according to Board policy. Ms. Muller reported to the Board that at the time of Dr. Olstein's admittance to MAP, all participants were placed on Five Years Probation for MAP regardless of their diagnosis being abuse or dependence. This case was reviewed by the Board's Evaluation Review Committee who recommended Dr. Olstein's MAP Probation be terminated based upon his diagnosis of substance abuse rather than dependence.

MOTION: Dr. Krishna moved to terminate the MAP Probation.
SECONDED: Dr. Lee

The Board clarified that the motion is to terminate Dr. Olstein's participation in MAP. The Board noted that Dr. Olstein will no longer be on Probation, but his Order will remain on the Board's web site indicating that only his Probation was terminated.

VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-07-0131A	A.A.	SCOTT A. WASSERMAN, M.D.	23328	Approve draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for knowingly making a fraudulent statement regarding his credentials on a patient consent form prior to surgery. Five Years Probation in addition to any other probationary order. Within six months obtain 20 hours CME in ethical issues related to surgical practice. The CME hours shall be in addition to the hours required for biennial renewal of medical license. Probation to include random chart reviews.

MOTION: Dr. Lee moved to approve the draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for knowingly making a fraudulent statement regarding his credentials on a patient consent form prior to surgery. Five Years Probation in addition to any other probationary order. Within six months obtain 20 hours CME in ethical issues related to surgical practice. The CME hours shall be in addition to the hours required for biennial renewal of medical license. Probation to include random chart reviews.
SECONDED: Dr. Krishna
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
12.	MD-06-0942A	AMB	ALAN K. OSUMI, M.D.	23063	Return for further investigation.

Dr. Goldfarb stated that he knew Mr. Gaines, but it would not affect his ability to adjudicate this case. Dr. Osumi was present and spoke during the call to public. He stated that his involvement in this case was with regard to his proxy signature of a lab report. He stated that his role was to check the integrity of the report and that if it was accurate, he would electronically sign it. Mr. Ed Gaines also addressed the Board during the call to public. He stated that Dr. Osumi's role was to ensure that the report made sense before electronically signing it. He said Dr. Osumi should not be held accountable for the contents of the report as he was not required to re-review the biophysical profile. Ingrid Haas, M.D., Medical Consultant, summarized the case for the Board. She stated that this case was before the Board at a previous meeting with the recommendation for an Advisory Letter. The Board rejected the recommendation and asked that the case return for further investigation. Following a second review, Board staff concluded that the proxy signature was appropriate and recommended dismissal.

Dr. Krishna stated that the physician who signs the report is approving the content of the document. Dr. Krishna noted that physicians may rely heavily on that document. Dr. Krishna spoke against the recommendation for dismissal and recommended an Advisory Letter. Anne Froedge, Assistant Attorney General, stated that the Board would have to agendize the item for a later meeting so that the physician would have adequate notice.

MOTION: Dr. Krishna moved to place the case on a future agenda with the recommendation for an Advisory Letter for failing to review the lab report prior to signing it. This case does not rise to the level of discipline.

Dr. Goldfarb noted that Radiologists are practicing proxy signature all over the state of Arizona. Dr. Lee suggested placing the issue on the Board's offsite meeting agenda. Board members recalled that the radiology technician read the labs and misinterpreted the biophysical profile and discussed that this case may have involved improper supervision of the radiology technician. Dr. Krishna withdrew his motion and recommended this case return for further investigation to re-review the original allegations.

MOTION: Dr. Krishna moved to return this case for further investigation.
SECONDED: Dr. Goldfarb
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

Dr. Martin instructed Board staff to add Proxy Signature to the Board's offsite meeting agenda.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
13.	MD-07-0520A	AMB	JEFFREY C. MCMANUS, M.D.	35573	Accept proposed consent agreement for a Letter of Reprimand with Five Years Probation for action taken by another state. Dr. McManus shall comply with the requirements of the California Medical Board Order. Probation to terminate upon completion of the terms of the California Medical Board's Order.

WEDNESDAY, JUNE 4, 2008

CALL TO ORDER
The meeting was called to order at 9:30 a.m.

ROLL CALL
The following Board Members were present: Dr. Goldfarb, Ms. Griffen, Ms. Ibáñez, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board member was absent: Dr. Pardo.

CALL TO PUBLIC
Statements issued during the call to public appear beneath the case referenced.

FORMAL HEARING MATTERS – CONSIDERATION OF ADMINISTRATIVE LAW JUDGE (ALJ) RECOMMENDATION

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0939A	J.B.	JAMES W. SCHOUTEN, M.D.	26278	Modify the ALJ's recommended Order for a Letter of Reprimand. Probation to undergo a PACE evaluation in emergency medicine, and 15 hours CME in emergency medicine including head injuries, anticoagulation and intubation, to be completed within four months. The CME is in addition to the CME required for license renewal. The physician's practice is restricted from emergency medicine until completion of the evaluation and upon demonstration of competence to the Board's satisfaction. The probation will terminate upon completion of the evaluation and PACE recommendations and upon completion of the CME. The physician is assessed half the cost of the hearing.

Board members indicated that they received and reviewed the administrative record from the ALJ. Dr. Schouten was present with legal counsel, Mr. Paul Giancola. Dr. Schouten addressed the Board during the call to public and gave a brief summary of the case. He said JB's neurological examination was normal. When she reported a headache, he stated that he immediately ordered a computed tomography (CT) scan. The scan was abnormal, demonstrating a subdural hematoma with midline shift. It then took Dr. Schouten one hour to obtain a neurosurgeon. Dr. Schouten stated that he has learned from this experience and has changed his practice. He further stated that he did the best he could while under very difficult circumstances.

Emma Mamaluy, Assistant Attorney General, presented this matter to the Board. She stated that JB's husband testified at the Formal Hearing that upon presentation to the emergency room, the staff was informed that JB was nauseous and had a headache. Ms. Mamaluy stated that Dr. Schouten performed an incomplete and poorly documented neurological examination of JB. Dr. Schouten claimed he had other patients to tend to while treating JB; however, Ms. Mamaluy stated that there were no other patients that had a fatal condition such as JB. Dr. Schouten also claimed that he provided an airway to JB, but it was later determined that another physician had done so. Ms. Mamaluy stated that he did not expedite the CT scan and failed to monitor JB. She stated that the credibility in this case was a serious issue. She asked that the Board modify the ALJ's recommended Order to assess the cost of the Formal Hearing to Dr. Schouten.

Mr. Giancola stated that there was no allegation that Dr. Schouten caused JB actual harm. Mr. Giancola stated that since JB was under Dr. Schouten's care, it was his responsibility to make sure that the airway was provided to her, regardless of what provider did it. The records establish that JB only reported head pain in the area of the laceration. Dr. Schouten admitted that his neurological exam was not adequately documented in JB's medical record. Dr. Schouten did not perform a complete neurological exam because the examination was more focused. Mr. Giancola stated that with no harm to JB, he suggested the Board modify the ALJ's recommended Order to issue Dr. Schouten a Letter of Reprimand rather than a Decree of Censure. Ms. Mamaluy readdressed the Board stating that there was no actual harm alleged, but there was potential harm and obvious negligence. Ms. Mamaluy stated that JB was a high risk patient that needed specific urgent care that Dr. Schouten failed to provide. At the Hearing, Dr. Schouten testified that he would do things similarly if faced with the same case in the emergency room.

MOTION: Dr. Krishna moved to modify the ALJ's recommended Findings of Fact to delete Findings of Fact #104 and to accept the grammatical changes as proposed by Board counsel and to modify Conclusions of Law #6 and #7 as recommended.
SECONDED: Dr. Petelin
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Dr. Krishna stated that he believed this case does not rise to the level of a Decree of Censure and recommended modifying the ALJ's recommended Order and issue Dr. Schouten a Letter of Reprimand and CME in emergency medicine including head injuries, anticoagulation and intubation.

MOTION: Dr. Krishna moved to modify the ALJ's recommended Order for a Letter of Reprimand. Probation to undergo a PACE evaluation in emergency medicine, and 15 hours CME in emergency medicine including head injuries, anticoagulation and intubation, to be completed within four months. The CME is in addition to the CME required for license renewal. The physician's practice is restricted from emergency medicine until completion of the evaluation and upon demonstration of competence to the Board's satisfaction. The probation will terminate upon completion of the evaluation and PACE recommendations and upon completion of the CME. The physician is assessed half the cost of the hearing.

Dr. Lee supported issuing Dr. Schouten a Decree of Censure and assessing the cost of the Hearing to Dr. Schouten. Dr. Goldfarb stated that a funduscopic examination should have been part of Dr. Schouten's limited neurological examination for a patient who sustained a head injury from a fall. Dr. Goldfarb also stated that when a patient is anticoagulated, the physician needs to be suspicious of intracranial bleeding. Dr. Goldfarb spoke in favor of the motion as this was Dr. Schouten's first time before the Board. Board members expressed concern that Dr. Schouten should not return to emergency medicine until he demonstrates his competence to do so. Dr. Schneider spoke against the motion. Drs. Krishna and Petelin agreed to amend their motion to include assessing half the cost of the Formal Hearing to Dr. Schouten

SECONDED: Dr. Petelin
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Ibáñez, Dr. Krishna, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, and Ms. Proulx. The following Board members voted against the motion: Ms. Griffen, Dr. Lee, and Dr. Schneider. The following Board member was absent: Dr. Pardo.
VOTE: 8-yay, 3-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-07-0549A	A.H.	RICHARD A. WAGNER, M.D.	26957	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for providing high-dosed IV narcotics for an acute gout attack, failing to respond to adverse signs of medication, and for inadequate medical records.

Dr. Wagner was present with legal counsel, David E. Hill. Dr. Goldfarb said he knew Mr. Hill, but it would not affect his ability to adjudicate the case. Bhupendra Bhatheja, M.D., Medical Consultant, summarized the case for the Board. Board staff found that Dr. Wagner deviated from the standard of care by treating AH's acute attack of gout with high-dose IV narcotics at the same time he provided Toradol, and by failing to respond to the signs and symptoms of narcotic drug overmedication and provide Narcan to AH. Board staff also found that Dr. Wagner failed to document any repeat examination of AH to support his clinical decision making. Dr. Wagner stated that he felt he met the standard of care in this case and that repeated examinations are typically not documented while in the emergency room if the findings are normal.

MOTION: Dr. Krishna moved to accept the Motion for Good Cause for providing supplemental material after the deadline for submission of materials to the Board.
SECONDED: Dr. Lee
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

Dr. Krishna led the questioning. Dr. Wagner stated that he chose to give AH an anti-inflammatory and an opiate because he felt that AH needed something to ambulate him until his gout could be controlled as his pain was so severe. Dr. Wagner admitted that he failed to document the multiple times that he saw AH while in the emergency room. He further stated that while in the emergency room, emergency room physicians may do things that do not make it into the medical record. Dr. Wagner also failed to document AH's vital signs. Dr. Wagner stated he believed AH developed non-cardiogenic pulmonary edema from the anti-inflammation medication. He stated that he believed AH's respiratory function would have improve once the opiate wore off and; therefore, did not intervene. Dr. Wagner stated that in the emergency room he may write an order for Narcan, but the nurse may administer a smaller dose. Dr. Wagner told the Board that he has learned from this experience and has changed his recordkeeping. He also stated that he is far more cautious with narcotics. In closing, Mr. Hill stated that it is unfair to draw violations from the charting when the nurses involved were not interviewed during the investigation process. He requested that the Board issue Dr. Wagner an Advisory Letter as the standard of care was met in this case.

MOTION: Dr. Krishna moved for a finding of unprofessional conduct under A.R.S. §32-1401(27)(e)- Failing or refusing to maintain adequate records on a patient; A.R.S. §32-1401(27)(q) – Any conduct that is or might be harmful or dangerous to the health of the patient or the public; and A.R.S. §32-1401(27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Dr. Martin
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Krishna moved for a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for providing high-dosed IV narcotics for an acute gout attack, failing to respond to adverse signs of medication, and for inadequate medical records.
SECONDED: Dr. Lee

Dr. Petelin spoke in favor of the motion and stated that Dr. Wagner failed to recognize that AH had an adverse reaction to the Toradol. Dr. Mackstaller spoke against the motion and recommended an Advisory Letter as this was a one time occurrence.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Martin, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board members voted against the motion: Ms. Ibáñez, Dr. Lefkowitz, and Dr. Mackstaller. The following Board member was absent: Dr. Pardo.
VOTE: 8-yay, 3-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-07-0128A	AMB	MARK D. GOLDBERG, M.D.	18592	Return for further investigation.

Dr. Goldberg was present with legal counsel, Stephen W. Myers. Dr. Bhatheja summarized the case for the Board. Board staff found that Dr. Goldberg failed to take a thorough medical history and perform a physical examination, as SE's medical chart contained no history or physical examination prior to beginning the procedures or during follow up visits. Dr. Goldberg's laser equipment and operators were not properly registered with the Arizona Radiation Regulatory Agency (ARRA), and Dr. Goldberg allowed an employee to practice under his supervision while her nursing license had lapsed. Vicki Johansen, Case Manager, reported to the Board that the esthetician in Dr. Goldberg's practice was administering lidocaine when he/she was not trained to do so. Dr. Goldberg told the Board that his practice began laser hair removal in 2004. He stated that he would perform a consultation with the patients rather than conduct a history and physical examination. He further stated that the law did not require him to personally see the patients prior to the hair removal treatments. Dr. Goldberg said he does not have a standard dosage for administering lidocaine to patients.

Dr. Goldberg informed the Board that SE was referred to his practice by her father who was a retired physician. Dr. Goldberg recalled SE's father had prescribed her medication prior to the procedure. Dr. Goldberg claimed that he was unaware of the nurse's lapsed license. He stated that he checks credentials when he hires a new employee, but does not check annually. Dr. Goldfarb noted that there were no medication logs for the time period that he treated SE and that Dr. Goldberg failed to establish a doctor-patient relationship with her prior to prescribing or the administration of the lidocaine. Dr. Goldberg stated that a new employee had started a new medication log in a new format and more than likely threw the old one away. In closing, Mr. Myers stated that there was a comprehensive record for every hair removal treatment and the only deficiency was with the lack of written orders for lidocaine. Mr. Myers noted that onsite supervision is not required for administering the laser hair removal treatments. He asked that the Board dismiss this case or issue Dr. Goldberg an Advisory Letter. Ms. Johansen reiterated that estheticians are not trained to administer the lidocaine injections. Dr. Goldberg claimed that the esthetician had previously worked as a dental and medical assistant; however, he did not provide the Board with that individuals employment records to verify her credentials.

MOTION: Dr. Goldfarb moved to go into executive session.
SECONDED: Dr. Krishna
Vote: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

The Board went into Executive Session for legal advice at 3:02 p.m.
The Board returned to Open Session at 3:19 p.m.
No deliberations or discussions were made during Executive Session.

Dr. Martin asked Dr. Goldberg and Mr. Myers if they were willing to waive the notice for Dr. Goldberg's failure to establish the doctor-patient relationship prior to prescribing. Mr. Myers and Dr. Goldberg declined. Dr. Martin recommended returning this case for further investigation to allow Dr. Goldberg the opportunity to respond to the re-notice of concerns raised during the Formal Interview.

MOTION: Dr. Martin moved to return this case for further investigation.
SECONDED: Dr. Goldfarb
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

CALL TO PUBLIC
Robert L. Mahanti, M.D., was present and addressed the Board during the call to public. He stated that he attended the Board's February 2008 meeting to inform the Board of multiple mistakes made in the process of receiving an Advisory Letter with non-disciplinary CME. Dr. Mahanti stated that in the Staff Investigational Review Committee (SIRC) a mistake was made in the reading of a subsequent physician medical record and that the mistake caused the process to proceed to an interview before the Board. In addition, Dr. Mahanti stated that SIRC also chose to ignore exculpatory information. Dr. Mahanti also expressed concern that responses to Board members during his interview with the Board were subsequently misinterpreted regarding his knowledge of steroid related complications. Dr. Mahanti stated that he was confused in that the medical record course required by the Board related to physicians using computerized records. According to Dr. Mahanti, he already utilized computerized records. He said his appeal rights were violated as he was not afforded the opportunity to appeal the Order for non-disciplinary CME. He stated that the February 2008 meeting draft minutes were inaccurate with reference to a new charge made against him; therefore, he wrote to the Board requesting modifications to accurately reflect what was stated, but his request was denied. He stated his experience with the Board had led him to believe that there is no recourse in the terms of receiving an Advisory Letter. He requested that the record reflect his criticisms of the Board's process.

All other statements issued during the call to public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-07-0638A	AMB	XAVIER MARTINEZ, M.D.	18944	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for habitual intemperance, using controlled substances not prescribed to him by another physician, for prescribing controlled substances to an immediate family member, and for prescribing medication for an extended period of time without conducting a physical examination. Five Year Probation to participate in MAP. Dr. Martinez shall receive credit for the time he has participated in MAP under an interim agreement.

Dr. Martinez was present with legal counsel, Kraig Marton. Elle Steger, Case Manager, summarized the case for the Board. Based upon Dr. Martinez's treatment records and his own admissions he admitted that he used medications that were not prescribed to him and he had prescribed controlled substances to his wife, on one occasion, diverting to himself. Board staff found that Dr. Martinez had only a one-page medical record for patient AM and he had been prescribing her numerous medications telephonically without conducting an examination for a period of two years. Dr. Martinez requested the Board allow him to enter into a Stipulated Rehabilitation Agreement (SRA). He stated that the allegations of the complaint were false, but admitted to the Board that he was an addict. He said the Board typically allows physicians who self-report to enter into a SRA for confidentiality purposes. Board members noted that Dr. Martinez had admitted to prescribing Lorazepam to himself and Dr. Martinez reported that he is no longer dependent on benzodiazepines.

Dr. Martinez stated that he no longer sees family members as patients and has instituted changes in his practice to avoid doing so. Patient AM presented to Dr. Martinez's office on one occasion. AM was the sister of Dr. Martinez's office manager and resided in Wyoming. Dr. Martinez continued AM's prescriptions for Duragesic and hydromorphone while she sought follow up care in Wyoming. AM reported to Dr. Martinez that the Duragesic was no longer working and he started her on the Fentanyl patch. Kathleen Muller, Physician Health Program, informed the Board that Dr. Martinez did not meet the criteria of confidentially and; therefore, did not meet the criteria for a SRA. Mr. Marton stated that Dr. Martinez requested the SRA, as he did not want the terms to be public and that Dr. Martinez has lost 70 percent of his practice due to this case. He asked that the Board consider this matter to be a self-report as Dr. Martinez reported his addiction to the Board. Pat McSorley, Case Review Manager, informed the Board that had the complaint not been filed, the Board would have never known of Dr. Martinez's use of drugs.

MOTION: Dr. Mackstaller moved to go into executive session.
SECONDED: Ms. Proulx
Vote: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

The Board went into Executive Session for legal advice at 4:03 p.m.
The Board returned to Open Session at 4:13 p.m.
No deliberations or discussions were made during Executive Session.

MOTION: Dr. Mackstaller moved for a finding of unprofessional conduct under A.R.S. §32-1401(27)(f) - Habitual intemperance in the use of alcohol or habitual substance abuse; A.R.S. §32-1401(27)(g) - Using controlled substances except if prescribed by another physician for use during a prescribed course of treatment; A.R.S. §32-1401(27)(h) - Prescribing or dispensing controlled substances to members of the physician's immediate family; and A.R.S. §32-1401(27)(ss) - Prescribing, dispensing or furnishing a prescription medication or a prescription-only device as defined in section 32-1901 to a person unless the licensee first conducts a physical examination of that person or has previously established a doctor-patient relationship.
SECONDED: Dr. Krishna
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Dr. Mackstaller recommended a Letter of Reprimand and Five Years Probation for Dr. Martinez to participate in the Board's Monitored Aftercare Program (MAP) under an SRA.

MOTION: Dr. Mackstaller moved for a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for habitual intemperance, using controlled substances not prescribed to him by another physician, for prescribing controlled substances to an immediate family member, and for prescribing medication for an extended period of time without conducting a physical examination. The physician shall enter into a confidential SRA for MAP for five years. Dr. Martinez shall receive credit for the time he has participated in MAP under an interim agreement.
SECONDED: Ms. Griffen

Dr. Martin noted that allowing Dr. Martinez to enter into an SRA would not be consistent with the Board's procedures. Dr. Martin spoke against the motion as this case stemmed from a patient complaint. Drs. Lee and Krishna also spoke against the motion.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Ms. Griffen, Dr. Lefkowitz, Dr. Mackstaller, and Dr. Petelin. The following Board members voted against the motion: Ms. Ibáñez, Dr. Krishna, Dr. Lee, Dr. Martin, Ms. Proulx, and Dr. Schneider. The following Board member was abstained: Dr. Goldfarb. The following Board member was absent: Dr. Pardo.
VOTE: 4-yay, 6-nay, 1-abstain, 0-recuse, 1-absent.
MOTION FAILED.

MOTION: Dr. Mackstaller moved for a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for habitual intemperance, using controlled substances not prescribed to him by another physician, for prescribing controlled substances to an immediate family member, and for prescribing medication for an extended period of time without conducting a physical examination. Five Year Probation to participate in MAP. Dr. Martinez shall receive credit for the time he has participated in MAP under an interim agreement.
SECONDED: Dr. Krishna
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Ms. Griffen, Ms. Ibáñez, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board member was abstained: Dr. Goldfarb. The following Board member was absent: Dr. Pardo.
VOTE: 10-yay, 0-nay, 1-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-07-0749B	AMB	SUNGNAM JOE, M.D.	24593	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to recognize acute renal failure and the need for urgent urological evaluation, and for inadequate medical records.

Dr. Joe was present with legal counsel, Mr. Thomas Bakker. Kathleen Coffer, M.D., Medical Consultant, summarized the case for the Board. Board staff found that Dr. Joe failed to obtain a urology consult in an urgent manner, failed to discontinue Meperidine in a patient with renal insufficiency, and failed to maintain adequate medical records. Board staff recommended an Advisory Letter. At its April 2008 meeting, the Board rejected the recommendation and instructed Board staff to invite Dr. Joe for a formal interview. Dr. Joe stated that in his experience, it is customary for the consultant to decide when to conduct an evaluation. He admitted that he should have been more involved in obtaining the consultation in a timelier manner. Dr. Joe told the Board that he has changed his practice as he personally contacts consultants to discuss his cases.

Dr. Goldfarb stated that Dr. Joe failed to document the urgent need for the urology consult. Dr. Joe stated that he ordered a nephrology consultation as the patient's presentation was consistent with pulmonary edema. Dr. Goldfarb noted that the patient only had one kidney and stated that a urology consultation should have been Dr. Joe's first priority in this case. The urologist ultimately saw the patient and performed surgery; however, the patient arrested and subsequently died. In closing, Mr. Bakker

stated that it was clear that there were deficits in the consultation requests. He asked that the Board consider the fact that Dr. Joe has no prior Board history. Dr. Goldfarb opined that Dr. Joe failed to understand the urgency of the situation for a deteriorating patient with one kidney, and failed to consult directly with the urologist when an urgent consult was needed.

MOTION: Dr. Goldfarb moved for a finding of unprofessional conduct under A.R.S. §32-1401(27)(e) – Failing or refusing to maintain adequate records on a patient; and A.R.S. §32-1401(27)(q) – Any conduct that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Dr. Krishna
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Goldfarb moved for a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to recognize acute renal failure and the need for urgent urological evaluation, and for inadequate medical records.
SECONDED: Dr. Krishna

Dr. Goldfarb clarified that there was no documentation that the urologist was contacted; therefore, a recordkeeping violation was sustained.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Ms. Ibáñez, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board member was absent: Dr. Pardo.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-07-0772A	D.E.	JOSEPH A. LONGO, M.D.	18636	Dismiss.

Dr. Martin was recused from this case. Dr. Longo was present with legal counsel, Mr. Vince Montell. Gerald Moczynski, M.D., Medical Consultant, summarized the case for the Board. Board staff found that Dr. Longo failed to inform the patient of an adverse event after a prosthesis was placed, failed to address continued pain and progressive subsidence postoperatively, and failed to maintain adequate medical records. Board staff recommended an Advisory Letter and at its April 2008 meeting, the Board rejected the recommendation and instructed Board staff to invite Dr. Longo for a formal interview. Dr. Longo stated that there was no evidence of a prosthetic fracture intraoperatively, but he subsequently noted subsidence. Dr. Longo stated that he first saw evidence of the fracture during the patient's January 31, 2006 visit. Dr. Longo said he was not sure how or when the fracture occurred. He said there was no indication for surgical intervention and decided to follow conservatively. In closing, Mr. Montell stated that Dr. Longo did not see the patient in follow up as she sought care elsewhere. Mr. Montell said Dr. Longo was treating the prosthesis conservatively and within the standard of care. Dr. Moczynski stated that there was no indication in the progress notes that the fracture was recognized and there were no recommendations documented. Dr. Krishna commented that Dr. Longo seemed to be a very competent physician and stated that Dr. Longo recognized the complication and followed it appropriately.

MOTION: Dr. Krishna moved for dismissal.
SECONDED: Dr. Lefkowitz
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Ms. Ibáñez, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board member was recused: Dr. Martin. The following Board member was absent: Dr. Pardo.
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

THURSDAY, JUNE 5, 2008

CALL TO ORDER
The meeting was called to order at 8:04 a.m.

ROLL CALL
The following Board Members were present: Dr. Goldfarb, Ms. Griffen, Ms. Ibáñez, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board Member was absent: Dr. Pardo.

CALL TO PUBLIC
SP was present and spoke during the call to public on behalf of her case that was dismissed by the Executive Director. SP stated that she received her dismissal letter a day prior to this meeting and wanted to appeal. She claimed that her case was not thoroughly investigated as none of her witnesses had been contacted. She asked that the Board reopen her case and contact each witness she included in her complaint.

Gene R. Meger, M.D., addressed the Board during the call to public. He stated that following the effective date of the Office Based Surgery Rules, his practice has changed. He said his practice performs office based procedures on healthy patients that may warrant an overnight stay for monitoring. He was concerned that continuing this in his practice may be in violation of the Board's

Rules. He requested that the Board revisit the Rules to consider revising the section involving prohibition from performing office based surgery on patients that may require inpatient postoperative care.

All other statements issued during the call to public appear beneath the case referenced.

OTHER BUSINESS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-1248A	AMB	LOUIS B. FLORES, M.D.	22613	Rescind referral to Formal Hearing and accept proposed consent agreement for a Letter of Reprimand for failing to maintain adequate records on a patient.

Emma Mamaluy, Assistant Attorney General, presented this case to the Board. She stated that this was an older case that involved improper prescribing of pain medications and inadequate medical recordkeeping. Ms. Mamaluy stated that Dr. Flores has had no further actions by the Board and that he is currently practicing in another state.

MOTION: Dr. Lee moved to rescind referral to Formal Hearing and accept the proposed consent agreement for a Letter of Reprimand for failing to maintain adequate records on a patient.
SECONDED: Ms. Griffen
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Ms. Ibáñez, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board member was absent: Dr. Pardo.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-03-0975A	AMB	KURT A. BUZARD, M.D.	19397	Rescind referral to Formal Hearing and accept the proposed consent agreement for a Letter of Reprimand for action taken by the Nevada Medical Board.

Maria Nutile was present on behalf of Dr. Buzard. She briefly summarized the case for the Board stating that it involved an arrest in Nevada that resulted in a public reprimand by that state's medical board. Ms. Nutile stated that the reprimand specifically stated there were no patient care issues resulting from Dr. Buzard's actions. She stated that the reprimand caused a domino affect with other states where Dr. Buzard holds a medical license. Ms. Nutile informed the Board that Dr. Buzard no longer practices medicine due to a disability. He surrendered his medical license in New York, he was granted inactive status in Nevada, and was granted disabled status in California.

Dean Brekke, Assistant Attorney General, presented this case to the Board. Mr. Brekke stated that this case involved a misdemeanor possession of illegal drugs. Mr. Brekke recommended the Board rescind the referral to Formal Hearing and accept the proposed consent agreement for a Letter of Reprimand, as Dr. Buzard does not plan to return to practice and has failed to renew his license. Mr. Brekke clarified that should the Board impose the discipline, Dr. Buzard's license would expire at the closing of this case.

MOTION: Dr. Mackstaller moved to rescind referral to Formal Hearing and accept the proposed consent agreement for a Letter of Reprimand for action taken by the Nevada Medical Board.
SECONDED: Ms. Griffen
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Ms. Ibáñez, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board member was absent: Dr. Pardo.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-07-0412A	AMB	ELI J. HAMMER, M.D.	17176	Deny the motion for rehearing or review.

Debra Hill was present on behalf of Dr. Hammer. She briefly summarized the request for rehearing or review. She stated that the Administrative Law Judge concluded at Formal Hearing that there was no basis for the Board ordering Dr. Hammer to undergo an evaluation and that the violation of Board Order was unwarranted. In addition, Ms. Hill stated that there was no basis in the record for the additional language that the Board included in the Conclusions of Law of the Administrative Law Judge's recommended Order. She requested that the Board remove the language and adopt the original Order, as the additional language was not relevant nor was it supported by the record. Dean Brekke, Assistant Attorney General, presented this matter to the Board. He stated that the editorial comments in the Conclusions of Law did not change the ultimate outcome of the case.

MOTION: Dr. Krishna moved to go into executive session.
SECONDED: Ms. Proulx
Vote: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The Board went into Executive Session for legal advice at 8:45 a.m.

The Board returned to Open Session at 8:47 a.m.
No deliberations or discussions were made during Executive Session.

MOTION: Dr. Krishna moved to deny the motion for rehearing or review.
SECONDED: Dr. Martin
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-05-0866A	AMB	TIMOTHY J. GELETY, M.D.	21851	Grant a rehearing.

Dr. Schneider was recused from this case. Paul Giancola was present on behalf of Dr. Gelety. He stated that he filed the motion for rehearing or review as there was an inadequate number of Board members who voted in favor of the Board's final decision. Mr. Giancola stated that the Findings of Fact in the final Order should be consistent with those of the Superior Court from which this case was remanded back to the Board. Mr. Giancola asked that the Board review the proposed changes to the Findings of Fact and then reconsider the discipline imposed. Mr. Brekke presented this case to the Board. He stated that the Board's vote was not improper under the State's statutes. Mr. Brekke said he reworded Findings of Fact #4 to comply with the findings made by the Superior Court. He asked that the Board grant the motion for rehearing for limited review of the proposed change to the Findings of Fact and the imposed discipline.

MOTION: Dr. Krishna moved to go into executive session.
SECONDED: Dr. Mackstaller
Vote: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

The Board went into Executive Session for legal advice at 8:54 a.m.
The Board returned to Open Session at 9:07 a.m.
No deliberations or discussions were made during Executive Session.

MOTION: Dr. Goldfarb moved to grant a rehearing.

Dr. Goldfarb clarified that a full rehearing would be more beneficial than a limited rehearing for the purposes of amending the Findings of Fact and discipline because the composition of the Board has changed and because the Board's previous vote was split.

SECONDED: Dr. Krishna
VOTE: 9-yay, 1-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-02-0749A	AMB	HARA P. MISRA, M.D.	14933	Deny the motion for rehearing or review.

Dr. Krishna was recused from this case. Pete Fisher was present on behalf of Dr. Misra. Mr. Fisher summarized the case for the Board. Dr. Misra placed a vena cava filter to prevent a potential pulmonary embolism in patient CM. The Board considered this case at two separate formal interviews in August 2004 and April 2005. The Board was concerned with Dr. Misra's failure to obtain a cardiologist to perform an electrocardiogram. The Board voted to issue Dr. Misra a Decree of Censure with Probation and CME. The Board's decision was appealed to the Court of Appeals and the Judge found that there was no actual harm to CM. The Board subsequently changed the language to potential harm and voted to issue a Letter of Reprimand rather than a Decree of Censure. Mr. Fisher stated that the Board had no basis to do so as the Court of Appeals found that there was no actual harm to CM and therefore, vacated the Board's finding of unprofessional conduct. He stated the Board should return the case to Formal Hearing in order to make a new finding of unprofessional conduct. Mr. Brekke informed the Board that the Court of Appeals did not mandate a new evidentiary hearing and that he believed no further action was warranted. Mr. Fisher reiterated that he believed the Court of Appeals vacated the Board's finding of unprofessional conduct and that another hearing or interview was necessary. Dr. Goldfarb noted that the Court of Appeals upheld the Board's finding of Dr. Misra's deviation from the standard of care.

MOTION: Dr. Goldfarb moved to go into executive session.
SECONDED: Dr. Schneider
Vote: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The Board went into Executive Session for legal advice at 9:26 a.m.
The Board returned to Open Session at 9:30 a.m.
No deliberations or discussions were made during Executive Session.

MOTION: Dr. Lee moved to deny the motion for rehearing or review.
SECONDED: Dr. Schneider
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-98-0743A	DHS	JAMES C. LOOMIS, M.D.	13971	Rescind referral to formal hearing and dismiss.
7.	MD-98-0743B	DHS	JOSEPH T. ZERELLA, M.D.	29913	Rescind referral to formal hearing and dismiss.

Dr. Petelin stated he knew Drs. Loomis and Zerella, but it would not affect his ability to adjudicate the case. Dr. Lefkowitz stated the same. Dr. Loomis addressed the Board during the call to public on behalf of himself and Dr. Zerella. He stated that this case occurred ten years ago. The circulating nurse brought the wrong patient to the operating room by not following the hospital's stipulated policy. Dr. Loomis stated that the patients were so remarkably similar in appearance, that the mistake was not recognized. This case was first brought to the Board with the recommendation of an Advisory Letter. The Board rejected the recommendation and instructed Board staff to invite the physicians for Formal Interview in 2001. The Board voted to issue the physicians Letters of Reprimand and the decision was appealed. At the rehearing, no additional information was provided and the Board declined to reverse its decision. This case was appealed in Superior Court and it was dismissed. This case was then sent back to the Board and the doctors were invited for Formal Interviews in 2003; however, the physicians opted for Formal Hearing.

Mr. Brekke presented this matter to the Board. He stated that the cases were at Superior Court at the same time that the Webb decision was published. Due to the Webb decision, the Superior Court found insufficient due process in this case and the case was dismissed. However, the law did not allow Superior Court to do so based upon due process alone therefore, this case was sent back to the Board. Mr. Brekke stated that both physicians have not had any complaints against them before or after this incident. Mr. Brekke further stated that based upon the record and the history of the two physicians, this was a non-disciplinary matter and he recommended an Advisory Letter.

MOTION: Dr. Petelin moved to rescind referrals to formal hearing and dismiss the cases.
SECONDED: Dr. Lee

Dr. Krishna spoke against the motion as the wrong patient was operated on. Dr. Krishna opined that the pediatric anesthesiologist should have caught the mistake prior to proceeding with the operation. Drs. Lee and Petelin supported the dismissal. Mr. Brekke reported to the Board that the Letters of Reprimand were available on the Board's web site for approximately a year, until the Superior Court dismissed it. Dr. Martin commented that it is unfair to apply today's standard of care to an incident that occurred ten years ago. However, Dr. Martin opined that operating on the wrong patient would have fallen below the standard of care ten years ago.

MOTION: Dr. Goldfarb moved to go into executive session.
SECONDED: Dr. Krishna
Vote: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The Board went into Executive Session for legal advice at 10:00 a.m.
The Board returned to Open Session at 10:11 a.m.
No deliberations or discussions were made during Executive Session.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Ms. Griffen, Ms. Ibáñez, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board members voted against the motion: Dr. Krishna and Dr. Martin. The following Board member was abstained: Dr. Goldfarb. The following Board member was absent: Dr. Pardo.
VOTE: 8-yay, 2-nay, 1-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-06-1028A	M.H.	SABA W. TESFAMARIAM, M.D.	30527	Rescind referral to Formal Hearing and issue an Advisory Letter for failing to monitor a patient's fluid status, failing to restart Lasix when it was indicated and for failing to follow up on an abnormal EKG. Within nine months obtain 20 hours non-disciplinary CME in cardiac issues with the emphasis on fluid retention and volume measurement. This matter does not rise to the level of discipline.

Ms. Mamaluy presented this matter to the Board. She stated that there were some quality of care issues in this case, but they were not egregious. She further stated that this case returned to the Staff Investigation Review Committee who reconsidered the case and recommended an Advisory Letter.

MOTION: Dr. Mackstaller moved to rescind referral to Formal Hearing and issue an Advisory Letter for failing to monitor a patient's fluid status, failing to restart Lasix when it was indicated and for failing to follow up on an abnormal EKG. Within nine months obtain 20 hours non-disciplinary CME in cardiac issues with the emphasis on fluid retention and volume measurement. This matter does not rise to the level of discipline.
SECONDED: Ms. Griffen

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Ms. Ibáñez, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board member was absent: Dr. Pardo.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-03-0443A	AMB	CAYETANO S. MUNOZ, M.D.	9506	Rescind referral to Formal Hearing and accept the proposed consent agreement for Surrender of an active license.

Mr. Brekke presented this matter to the Board stating that Dr. Munoz is no longer interested in practicing and consented to surrender his medical license.

MOTION: Dr. Goldfarb moved to rescind referral to Formal Hearing and accept the proposed consent agreement for Surrender of an active license.
SECONDED: Ms. Proulx
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Ms. Ibáñez, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board member was absent: Dr. Pardo.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-06-0939A	J.B.	JAMES W. SCHOUTEN, M.D.	26278	Accept proposed Order for a Letter of Reprimand. Probation to undergo a PACE evaluation in emergency medicine, and 15 hours CME in emergency medicine including head injuries, anticoagulation and intubation, to be completed within four months. The CME is in addition to the CME required for license renewal. The physician's practice is restricted from emergency medicine until completion of the evaluation and upon demonstration of competence to the Board's satisfaction. The probation will terminate upon completion of the evaluation and PACE recommendations and upon completion of the CME. The physician is assessed half the cost of the hearing

Ms. Mamaluy drafted a proposed Order in this case to correspond with the modifications to the ALJ's recommended decision. She conferred with opposing counsel and there were no objections to the changes.

MOTION: Dr. Lee moved to accept the proposed order.
SECONDED: Dr. Goldfarb
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Ms. Ibáñez, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board member was absent: Dr. Pardo.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-05-0175A	AMB	M. AZAM KHAN, M.D.	9994	Rescind referral to Formal Hearing and Dismiss the case.

Jerry Gaffaney, Outside Board Counsel, presented this matter to the Board. Drs. Goldfarb and Martin stated that they knew Mr. Gaffaney, but it would not affect their ability to adjudicate this case. Mr. Gaffaney stated that after a substantial investigation, it was determined that there was not enough evidence to support an EMTALA violation based on the allegation that Dr. Khan refused to come in and see the patient. Mr. Gaffaney recommended the Board rescind the referral to Formal Hearing and dismiss the case.

MOTION: Dr. Krishna moved to rescind referral to Formal Hearing and Dismiss the case.
SECONDED: Dr. Lee
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Ms. Ibáñez, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board member was absent: Dr. Pardo.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
1.	MD-07-0504A	L.K.	ANDREW J. APPEL, M.D.	33956	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for inadequate medical records and for improper placement of a pedicle screw resulting in neurological deficit.

LK was present and addressed the Board during the call to public. LK stated that he suffered postoperative complications that were not addressed by Dr. Appel. LK stated that he discovered many of his nerves were disconnected following surgery.

Following the removal of hardware by a subsequent provider, LK stated that he no longer experienced pain after the hardware was removed from his back. Dr. Appel was present with legal counsel, Mr. Stephen W. Myers. Gerald Moczynski, M.D., Medical Consultant, summarized the case for the Board. Board staff found that Dr. Appel deviated from the standard of care by failing to modify his surgical procedure and utilize intra-operative nerve root monitoring when visualization of the pedicles was difficult with fluoroscopy. Board staff was critical of Dr. Appel's recordkeeping, in that, his discharge summary was dictated almost six weeks after LK's discharge and failed to mention that LK required a second surgical procedure for the L4 nerve root palsy. Dr. Appel documented that the nerve root palsy at L4 resolved, but failed to include that the L5 root palsy did not.

Board members were presented with LK's CT scan demonstrating screw placement. Dr. Appel could not comment on the placement of the pedicle screw, but agreed that the scan was abnormal. He argued that the CT scan was two years postop and that the screw may have migrated during that timeframe. Dr. Appel explained that this was not an elected procedure as it was emergent. Dr. Appel noted complications and re-explored LK to ensure that the pedicle screw was not breaching the neural foramen. Dr. Appel found the screw was placed adequately and reinserted it into its hole. Dr. Appel stated that he would not have monitored LK's neurological status as this was not the standard of care, but agreed that LK had a change in his neurological status following the procedure. Dr. Appel stated that he did not have a higher index of suspicion with LK as he treats every patient with the best care he could provide. Dr. Appel admitted that his medical records were inadequate, but stated that this may have been due to his habit of talking very quickly; some words may have been dropped from his dictation.

In closing, Mr. Myers reported to the Board that Dr. Appel had attended a recordkeeping course to improve his documentation. Mr. Myers stated that LK's nerve root injury may have existed prior to his surgery with Dr. Appel. Dr. Martin opined that there was no evidence to support repeated or gross negligence; however, he stated that there was clearly negligence resulting in harm to LK as his remaining leg was compromised due to Dr. Appel's surgery.

MOTION: Dr. Martin moved for a finding of unprofessional conduct under A.R.S. §32-1401(27)(e)- Failing or refusing to maintain adequate records on a patient; and A.R.S. §32-1401(27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Dr. Petelin
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Dr. Martin found that Dr. Appel had difficulty admitting that there was a mistake made and that this case rises to the level of discipline.

MOTION: Dr. Martin moved for a draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for inadequate medical records and for improper placement of a pedicle screw resulting in neurological deficit.
SECONDED: Dr. Krishna

Dr. Martin noted that this was a technical error, but the manner in which the complication was handled is what separated this case from other cases that did not rise to the level of discipline in the past. Dr. Krishna spoke in favor of the motion. Dr. Martin stated that Dr. Appel seemed to have learned from this experience and complimented him on the fact that he gave vigilance to LK not only because of his disability, but because he seems to treat all patients in the same manner.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Ms. Ibáñez, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Ms. Proulx, and Dr. Schneider. The following Board member voted against the motion: Dr. Petelin. The following Board member was absent: Dr. Pardo.
VOTE: 10-yay, 1-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
2.	MD-07-0335A	AMB	EDGARDO ZAVALA-ALARCON, M.D.	27016	Issue an Advisory Letter for making a false statement to the medical executive committee on behalf of another physician. 15 hours non-disciplinary CME in ethics to be completed within three months. The CME is in addition to the CME required for license renewal. This matter does not rise to the level of discipline.

Dr. Zavala-Alarcon was present with legal counsel, William Jones. Marlene Young, Case Manager, summarized the case for the Board. Board staff found that Dr. Zavala-Alarcon submitted a letter with false information to St. Luke's Medical Center on behalf of another physician. Board staff recommended an Advisory Letter and this case was placed on the Board's April 2008 meeting agenda. The Board rejected the recommendation and instructed staff to invite Dr. Zavala-Alarcon for a Formal Interview. Dr. Zavala-Alarcon was the Chief of Cardiology at the Maricopa Medical Center at the time of this incident. He did not recall dictating or drafting the letter, but did remember signing it without first verifying its accuracy.

Dr. Zavala-Alarcon stated that he left that position in March of 2007 to work with a cardiology group practice. He is currently in a private practice that mainly involves the treatment of venous insufficiency. Dr. Goldfarb noted that Dr. Zavala-Alarcon's letter was addressed to an individual on the Medical Executive Committee of that hospital. Dr. Zavala-Alarcon stated that he did not have any reason to not believe the statements in that letter were not true at the time that he signed it. In closing, Mr. Jones stated that

Dr. Zavala-Alarcon obviously made a mistake in retrospect. He stated that Dr. Zavala-Alarcon has been honest with the Board and that this type of incident will not happen again. Dr. Goldfarb stated that he did believe that Dr. Zavala-Alarcon knowingly made a false or fraudulent statement to the Committee. However, Dr. Goldfarb stated that the Committee had the right to rely upon the information it received. Dr. Krishna recommended issuing an Advisory Letter. Dr. Petelin spoke in support of an Advisory Letter and recommended adding non-disciplinary CME in ethics.

MOTION: Dr. Goldfarb moved to issue an Advisory Letter for making a false statement to the medical executive committee on behalf of another physician. 15 hours non-disciplinary CME in ethics to be completed within three months. The CME is in addition to the CME required for license renewal. This matter does not rise to the level of discipline.
SECONDED: Dr. Krishna
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Ms. Ibáñez, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board member was absent: Dr. Pardo.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC.#	RESOLUTION
3.	This matter was moved to Other Business item #13.			

CALL TO THE PUBLIC
Statements issued during the call to public appear beneath the case referenced.

LEGISLATIVE AFFAIRS UPDATE
Ms. Wynn introduced Stuart Goodman, who contracts as the Board's legislative liaison. He has been with the Board for approximately four to five legislative sessions. He reported that the fund deficit for fiscal year 2009 will be approximately $2.2 billion. He stated that the fund balance transfer has affected all 90/10 Boards in the State. Mr. Goodman defined a 90/10 Board as a regulatory agency in which 90% of the fees collected remain within the agency and 10% is automatically transferred to the State's general fund. He further stated that he provided a letter to the Governor on behalf of the Board that was intended to raise awareness of the impact that the fund transfers may potentially have in the future.

Legislative Update:
Senate Bill 1006: This Bill is intended to create a process that holds a license while the licensee is overseas on active duty. This Bill has been signed into law.
Senate Bill 1048: Partial-birth Abortions. This Bill has not moved forward.
Senate Bill 1078: Infectious Diseases: This Bill has been amended to better define which diseases and patient contact.
Senate Bill 1091: Training module for renewal and providing civil immunity for third parties. This Bill has gone through with no amendments.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
4.	MD-07-0399A	AMB	EDWARD P. FULLER, M.D.	26880	Issue an Advisory Letter for failing to appropriately diagnose a lesion resulting in an unnecessary mastectomy. This was a one-time only occurrence and there was insufficient evidence to support discipline.

Dr. Fuller was present with legal counsel, Ed Gaines. Dr. Goldfarb stated that he knew Mr. Gaines, but it would not affect his ability to adjudicate the case. Kathleen Coffer, M.D., Medical Consultant, summarized the case for the Board. Board staff found that Dr. Fuller deviated from the standard of care by failing to appropriately diagnose a lesion leading to mistreatment. She stated that a mastectomy would not have been required had Dr. Fuller made the correct diagnosis of a lobular carcinoma. Dr. Fuller stated that this had been a learning experience to him and that he completed CME courses to further educate himself. He stated that he had been practicing for twenty-seven years with no prior Board actions or lawsuits against him. He reported that he has taken action to prevent this same incident from reoccurring.

Dr. Petelin questioned if Dr. Fuller had a sense or feel that this may have been a difficult lesion to interpret. Dr. Fuller stated that he sent the slides to another provider to differentiate what was diagnosed. Board members noted that Dr. Fuller has no prior Board history and that this was his first complaint before the Board. However, had Dr. Fuller made the correct diagnosis, the patient would have been provided treatment options and she may not have chosen a mastectomy. In closing, Mr. Gaines stated that Dr. Fuller is an outstanding physician in the State of Arizona. He stated that a mastectomy was a reasonable treatment option at that time. Mr. Gaines reiterated that Dr. Fuller has learned from this case and has taken action to prevent the same thing from reoccurring. Dr. Petelin noted potential harm to the patient, but did not find that this case rises to the level of discipline.

MOTION: Dr. Petelin moved to issue an Advisory Letter for failing to appropriately diagnose a lesion resulting in an unnecessary mastectomy. This was a one-time only occurrence and there was insufficient evidence to support discipline.
SECONDED: Dr. Goldfarb

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Ms. Ibáñez, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board member was absent: Dr. Pardo.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The meeting adjourned at 5:32 p.m.

_____
Lisa Wynn, Executive Director